Superior Court Employees

2019
HEALTH BENEFITS

SAN FRANCISCO
HEALTH SERVICE SYSTEM

What's New and Available for 2019

2019 Medical, Dental and VSP Premier Plan Premium Contributions are Changing. City Plan PPO Co-Pays for Prescription Drugs and Out-of-Network Deductibles Have Increased

Review the rates for your bargaining unit at sfhss.org before making your Open Enrollment elections. City Plan PPO co-pays for prescription drugs have increased along with deductibles for out-of-network services. See pages 12, 16 and 19 for more details.

Blue Shield of California's Trio HMO Plan Offers Concierge Support for Members

The Trio HMO Plan, now in its second year, provides the exact same benefits and plan design as the Access+ HMO, with lower premium contributions, and access to many of the same hospitals and physicians. If you are a current Access+ HMO enrollee, but your doctors are in the Trio Network, you may choose to select a lower premium contribution for the exact same benefits. Please call the dedicated Trio HMO Concierge line at (855) 747-5800 or visit blueshieldca.com/sites/imce/trio.sp.

New and Existing Blue Shield Trio HMO Members Eligible for Sun Basket Custom Home Meals Delivery

Starting in January, new and currently enrolled Trio HMO members will be eligible to receive a two-week complimentary subscription to Sun Basket (sunbasket.com) for custom home delivered meals. Sun Basket is a healthy meal-kit service that delivers organic, sustainable ingredients and easy recipes for cooking at home. Offer includes three customizable meals a week for two people, over the two-week period. To qualify, Trio HMO enrollees need complete their annual preventive care visit within the first 90 days of enrollment. Existing Trio members can provide proof of a completed annual preventive care visit within the previous nine months.

Health Flexible Spending Account Maximum Increasing to $2,650

The maximum amount of pre-tax dollars you can set aside for reimbursement for qualified medical and healthcare-related expenses will increase from $2,500 to $2,650 starting January 1, 2019. See page 20.

Delta Dental PPO New *SmileWay* Program, Adult Orthodontia Lifetime Max Increase, and Dental Accident Benefits

Beginning January 1, 2019, Delta Dental PPO enrollees who have certain chronic conditions (diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and/or stroke), will be able to receive an annual periodontal scaling and root planing procedure (deep cleaning of gums) as well as more frequent annual teeth cleaning and/or periodontal maintenance services. The adult orthodontic lifetime maximum will increase from $1,500 to $2,500. Dental Accident Benefits have been added to provide additional dental service coverage for conditions caused directly or independently of all other causes by external, violent, and accidental means. Pages 17-18.

VSP Vision Offers 100% Coverage for Standard Progressive Lenses

VSP Basic and Premier Plans are now offering 100% coverage (no co-pay) for standard progressive lenses. Additionally, if you are enrolled in the VSP Premier Plan, your co-pay for premium progressive lenses and custom progressive lenses will be $25. Basic Plan co-pays for premium and custom progressive lenses will not change. See pages 14-15.

Enroll in Voluntary Benefits through WORKTERRA (EBS)

Voluntary benefits can help provide additional financial protection for you and your family. SFHSS has partnered with WORKTERRA (EBS) to offer a suite of quality insurance plans to SFHSS members at discounted rates. Enrollment is optional. Plan premiums may be paid through payroll deduction. See page 21.

eBenefits Online Open Enrollment Now Available for Employees with Employee Portal Access!

SFHSS is excited to announce that ***eBenefits*** is now available to City and County of San Francisco active employees who have access to the City's Employee Portal through their Department. Members currently eligible to participate in ***eBenefits*** will receive special instructions in their 2019 Plan Year Open Enrollment letter. SFHSS will continue to roll out ***eBenefits*** to more members in 2019!

Remember to Check that Your Dependents are Still Eligible for Benefits

As stated in the San Francisco Health Service System Rules, dependent eligibility may be audited by SFHSS and proof of dependent eligibility may be required at any time. Failure to furnish such proof within thirty (30) days after a request shall result in termination of coverage. The enrollment of a dependent who does not meet eligibility requirements, or the failure to disenroll a dependent when they become ineligible, will be treated as an intentional misrepresentation of a material fact, or fraud.

This guide provides an overview of the San Francisco Health Service System rules approved by the Health Service Board. The rules can be found at sfhss.org. To request a paper copy of the rules call (415) 554-1750.

Executive Director's Message

The Greater Good is a Healthier You!

Administering benefits for over 120,000 active employees, retirees and their dependents is both a privilege and an undertaking. We are currently in an environment where health care is impacted by advancing technologies that are emerging at record speeds, in the face of ever-changing political and social divisions.

Our job is to navigate these waters on your behalf, while ensuring you receive comprehensive, quality benefits at the most competitive rates. Our approach to providing benefits is holistic, inclusive and aimed at offering cost-effective options that meet all your needs throughout your life.

For these reasons, we are committed to focusing on preventive health benefits and measures that empower each of you to take action and do your part to maintain your good health and well-being.

As you make your benefit selections this year, please consider taking advantage of all the preventive and annual care benefits available under your selected plans. Don't wait to use your benefits until you are ill.

We personally collaborate with health care providers, through our contracted health plans, to ensure that you are provided with benefits that support preventive health care. When you do your part, your provider can help you catch issues early and help you manage health concerns before they become serious. Schedule your annual check-ups, dental cleanings and exams in a timely manner.

Each medical and dental plan features its own annual check-up benefits, of which you should take advantage. In addition to maintaining your good health, you are supporting us in our mission to maintain quality-affordable health care by managing your own health. We all have a role to play. The choices you make today have a direct impact on the health care costs that you and your fellow employees will pay down the road.

We are steadfastly committed to providing benefits and programs that support your total health and well-being. We do this on several fronts: 1. Supporting your physical health by providing you with a variety of health plan options to meet your needs as well as well-being services that promote healthy lifestyles. 2. Supporting your financial health with benefits that protect you and your family in the event of disability, critical illness or death as well as offering Flexible Spending and Dependent Spending Accounts, which allow members to set aside pre-tax dollars to cover health-related expenses throughout the year. 3. Supporting your mental health through our mental health benefits with our health plans, and our Employee Assistance Program (EAP), which offers counseling and coaching services to all active members and their immediate family members, allowing them to meet confidentially with licensed therapists about personal or professional matters.

With affordable comprehensive and quality benefits in mind for 2019, I am happy to announce that Delta Dental PPO will be increasing their dental coverage for members with SmileWay, a new plan that expands dental cleaning coverage for members with chronic conditions like diabetes, heart disease, HIV/AIDS, rheumatoid arthritis, and stroke. VSP continues to augment benefits by including 100% coverage for standard progressive lenses. For members eligible for Flexible Spending Accounts (FSA), we are increasing the maximum to $2,650 next year.

I invite you to make 2019 the year that you engage in your lifelong journey of preventive health practices. Please explore our 2019 Benefits Guide to learn about all the ways you can maintain a healthier you in 2019 and the years to come!

Abbie Yant, RN, MA
Executive Director

How to Enroll in Health Benefits

- Learn about your health benefits options by reading this Benefits Guide and visiting sfhss.org.
- Eligible new and rehired employees must enroll in health coverage **within 30 calendar days from their hire date**. If you do not enroll within this 30-day period, you can only apply for benefits during the next Open Enrollment or within 30 days of a qualifying event, such as losing other coverage. See pages 6-7 for more information about qualifying events.
- To enroll, submit a completed enrollment application and required eligibility documentation to the San Francisco Health Service System by the **30-day deadline**. Submit copies (not originals) of eligibility documentation such as a certified marriage certificate, domestic partner certification and children's birth certificates. You may mail, fax or drop off your enrollment application and eligibility documentation. The fax number is (415) 554-1721.
- Employee premium contributions are deducted from paychecks biweekly. Review your paycheck to verify that the correct employee premium contribution is being deducted. The 2019 premiums are listed on pages 12, 16 and 19.
- October Open Enrollment is your annual opportunity to change benefit elections without any qualifying events. Changes made during October Open Enrollment are effective the following January 1st. It is also your opportunity to drop ineligible dependents without being charged a penalty.
- Questions about health benefits, premium contributions or eligibility documentation? **Call (415) 554-1750**.

Comprehensive, Affordable Benefits for Eligible Employees and their Families

The following rules govern which employees and dependents may be eligible for SFHSS health coverage.

Member Eligibility

The following are eligible to participate in the San Francisco Health Service System as members:

- All permanent employees of the City and County of San Francisco whose normal work week is not less than 20 hours.
- All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week is not less than 20 hours.
- All other employees of the City and County of San Francisco, including temporary exempt or "as needed" employees, who have worked more than 1,040 hours in any consecutive 12-month period and whose normal work week is not less than 20 hours.
- Elected Officials of the City and County of San Francisco.
- All members of designated boards and commissions during their time in service to the City and County of San Francisco as defined in San Francisco Administrative Code Section 16.700(c).
- All officers and employees as determined eligible by the governing bodies of the San Francisco Transportation Authority, San Francisco Parking Authority, Treasure Island Development Authority, San Francisco Superior Court and any other employees as determined eligible by ordinance.
- All other employees who are deemed "full-time employees" under the shared responsibility provision of the federal Patient Protection and Affordability Care Act (Section 4980H).
- Temporary exempt employees of the Superior Court appointed for a specified duration of greater than six months with a normal work week not less than 20 hours become eligible on their start date.

Dependent Eligibility

Spouse or Domestic Partner

A member's spouse or registered domestic partner may be eligible for SFHSS health coverage. Proof of legal marriage or domestic partnership is required, as well as the dependent's Social Security number.

Enrollment in SFHSS benefits must be completed within 30 days of the date of marriage or partnership. In that case, coverage begins on the first day of the coverage period after a completed application and eligibility documentation is filed with SFHSS.

A spouse or registered domestic partner can also be added to a member's coverage during Open Enrollment. A spouse covered on an employee's medical plan is not required to enroll in Medicare. A registered domestic partner who is eligible for Medicare is required to enroll in Medicare.

Natural Children, Stepchildren, Adopted Children

A member's natural child, stepchild, adopted child (including a child placed for adoption) and the natural or adopted child of a member's enrolled domestic partner are eligible for coverage up to 26 years of age. Coverage terminates at the end of the coverage period in which the child turns 26. Eligibility documentation is required upon initial enrollment.

Legal Guardianships and Court-Ordered Children

Children under 19 years of age placed under the legal guardianship of an enrolled member, a member's spouse, or domestic partner are eligible.

If a member is required by a court's judgement, decree, or order to provide health coverage for a child, that child is eligible up to age 19. Coverage terminates at the end of the coverage period in which the child turns 19. The member must provide SFHSS with proof of guardianship, court order, or decree by required deadlines.

Adult Disabled Children

To qualify a dependent disabled adult child, the adult child must be incapable of self-support because of a mental or physical condition that existed prior to age 26, continuously live with disability after turning 26, and meet each of the following criteria:

1. Disabled adult child ("Adult Child") is enrolled in a San Francisco Health Service System medical plan on his or her 26th birthday; and
2. Adult Child has met the requirements of being an eligible dependent child under SFHSS Member Rules Section B.3 before turning 26 years old; and
3. Adult Child must have been physically or mentally disabled on the date coverage would have otherwise terminated due to age, i.e. turning 26 years old, and continue to be disabled from age 26 on; and
4. Adult Child is incapable of self-sustaining employment due to the physical or mental disability; and
5. Adult Child is dependent on SFHSS Member for substantially all of his or her economic support, and is declared as an exemption on the Member's federal income tax;
6. Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter or upon request.
7. All enrolled dependents, including an Adult Child, who qualify for Medicare due to a disability are required to enroll in Medicare (see SFHSS Member Rules Section J). Members must notify SFHSS of any dependent's eligibility for Medicare, as well as any dependent's subsequent enrollment in Medicare.
8. To maintain ongoing eligibility after the Adult Child has been enrolled, the Member must re-enroll the Adult Child with SFHSS each year and must ensure that he or she remains continuously enrolled Medicare (if eligible) without interruption.
9. A newly hired employee who adds an eligible dependent Adult Child, who is age 26 or older, must meet all requirements listed, except (1.) and (2.) above and comply with their enrolled medical plan's disabled dependent certification process specified in (6.) within (30) days of employee hire date.

Medicare Enrollment Requirements for Dependents

SFHSS Rules require domestic partners, dependents with End Stage Renal Disease (ESRD) and children who have received Social Security insurance for more than 24 months to enroll in premium-free Medicare Part A and in Part B. Medicare coverage begins 30 months after disability application. Note that a member or dependent with ESRD may be prohibited from changing medical plan enrollment.

Medicare Enrollment Requirements When You Retire

Retirees and dependents who are eligible for Medicare must have Medicare Part A and Part B in effect when retiring. Proof of Medicare coverage is required by SFHSS before any Medicare-eligible individual can be enrolled in retiree health coverage. Failure to enroll in Medicare when first eligible may also result in a late-enrollment penalty from Medicare. The Medicare application process at Social Security often takes three months.

Penalties for Failing to Disenroll Ineligible Dependents

Members must notify SFHSS within 30 days and cancel coverage for a dependent who becomes ineligible. If a member fails to notify SFHSS, the member may be held responsible for the costs of ineligible dependents' health premiums and any medical service provided. October open enrollment is the only time to drop ineligible dependents without a penalty.

Changing Benefit Elections: Qualifying Events

You may change health benefit elections outside of Open Enrollment if there is a qualifying event.

To change benefit elections, you must complete the election change process, including the submission of all required documentation, no later than 30 calendar days after the qualifying event occurs.

If the election change process is not completed **within 30 days** of the date of the qualifying event, you must wait until the next Open Enrollment to make the change. Note that individuals with End Stage Renal Disease may be prohibited from changing medical plans. Below are the qualifying events that allow you to change your benefit elections.

New Spouse or Domestic Partnership

To enroll a new spouse or domestic partner and eligible children of a spouse or partner in San Francisco Health Service System (SFHSS) healthcare coverage, submit a completed SFHSS enrollment application, a copy of a certified marriage certificate or certificate of domestic partnership and a birth certificate for each child to SFHSS **within 30 days** of the legal date of the marriage or partnership. Certificates of partnership must be issued in the United States.

A Social Security number must be provided for each of the family members being enrolled. Proof of Medicare enrollment is also required for a domestic partner who is Medicare-eligible due to age or disability.

Coverage for your spouse or domestic partner will be effective the first day of the coverage period following the submission of the required application and documentation.

Newborn or Newly Adopted Child

Coverage for an enrolled newborn child will be effective on the child's date of birth. Coverage for an enrolled adopted child will be effective on the date the child is placed.

A Social Security number must be provided within six months of the date of birth or adoption, or your child's coverage may be terminated.

Legal Guardianship or Court Order

Coverage for a child under legal guardianship or court order shall begin upon effective date of guardianship or court order is submitted by the **30-day deadline.** Coverage for a dependent per a court order will be effective the date of court order, if all documentation is submitted to SFHSS by the 30-day deadline.

Divorce, Separation, Dissolution, Annulment

Coverage for an ex-spouse, domestic partner and stepchildren will terminate on the last day of the coverage period in which they occurred, provided you complete disenrollment **within 30 days.**

Failure to notify SFHSS can result in significant financial penalties equal to the total cost of benefits and services provided for any ineligible dependents.

Loss of Other Health Coverage

SFHSS members and eligible dependents who lose other health care coverage may enroll in SFHSS benefits. Once required documentation is submitted, SFHSS coverage will be effective on the first day of the next coverage period.

Obtaining Other Health Coverage

You may waive SFHSS coverage for yourself or a dependent who enrolls in other health coverage. If you waive coverage for yourself, coverage for all your enrolled dependents will also be waived.

After all required documentation (proof of coverage must be on letterhead) is submitted, SFHSS coverage will terminate on the last day of the coverage period.

Moving Out of Your Plan's Service Area

If you move your residence to a location outside your health plan's service area, you must enroll in a different SFHSS plan that offers service based on your new address. Coverage under the new plan will be effective the first day of the coverage period following receipt of required documentation.

Death of a Dependent

In the event of the death of a dependent, notify SFHSS as soon as possible and submit a copy of the death certificate **within 30 days** of the date of death.

Death of a Member

In the event of a member's death, the surviving dependent or survivor's designee should contact SFHSS to obtain information about eligibility for survivor health benefits.

After being notified of a member's death, SFHSS will send instructions to the spouse or partner, including a list of documentation required for enrolling in surviving dependent health coverage.

A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage, but must wait until Open Enrollment to enroll.

Changing FSA Contributions

Per IRS regulations, some qualifying events may allow you to initiate or modify Flexible Spending Account (FSA) contributions. Contact SFHSS at (415) 554-1750 for more information.

Responsibility for Premium Contributions

Change in coverage due to a qualifying event may change premium contributions. Review your paycheck to make sure premium deductions are correct. If the premium deduction is incorrect, contact SFHSS. You must pay any premiums that are owed. Unpaid premium contributions will result in termination of coverage.

The San Francisco Health Service System Provides You With Several Medical Plan Options

These medical plan options are available to employee members and eligible dependents.

Health Maintenance Organization (HMO)

An HMO is a medical plan that offers benefits through a network of participating physicians, hospitals and other healthcare providers. For non-emergency care, you access service through your PCP (Primary Care Physician) or an affiliated urgent care center. You do not pay a deductible before accessing benefits and co-pays at the point of service are set at a contracted rate. This helps to limit out-of-pocket costs. SFHSS offers the following HMO plans:

- Blue Shield of California Trio HMO
- Blue Shield of California Access+ HMO
- Kaiser Permanente HMO

Preferred Provider Organization (PPO)

A PPO is a medical plan that offers benefits through in-network and out-of-network healthcare providers. PPOs allow for a greater selection of providers. (Out-of-network providers will cost you more). You are not assigned to a Primary Care Physician, so you have more responsibility for coordinating your care. Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs. Like the HMO plans, the PPO has an out-of-pocket limit. You must pay a plan year deductible. You also pay a coinsurance percentage each time you access service. Because the City Plan PPO is a self-insured plan, individual premiums are determined by the total cost of services used by the plan's group of participants. SFHSS offers the following PPO plan:

- City Plan PPO

  UnitedHealthcare Select Plus
  f*or California Members*

  UnitedHealthcare Choice Plus
  for non-California Members

How To Enroll In Medical Benefits

Eligible full-time employees must enroll in an SFHSS medical plan within 30 calendar days of their start work date. Submit a completed enrollment application and eligibility documentation to SFHSS. If you do not enroll by required deadlines, you can only apply during Open Enrollment or due to a qualifying event. Coverage will start the first day of the coverage period after eligibility has been approved by SFHSS. Verify the date coverage will start with SFHSS when you enroll. Once enrolled, you must pay all required employee premium contributions. Review your paycheck to make sure correct deductions are being taken.

SFHSS does not guarantee the continued participation of any particular doctor, hospital or medical group in a medical plan. You cannot change your benefit elections because a doctor, hospital or medical group chooses not to participate. You will be assigned or required to select another provider.

An enrolled individual with End Stage Renal Disease may be prohibited by federal Medicare rules from changing health plans.

The Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect for each plan from January to December 2019. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Download plan EOCs at sfhss.org.

Medical Plan Service Areas

County	Kaiser Permanente HMO	Blue Shield Trio HMO	Blue Shield Access+ HMO	City Plan PPO
Alameda	■	■	■	■
Contra Costa	■	■	■	■
Marin	■	❍	■	■
Napa	❍			■
Sacramento	■	❍	■	■
San Francisco	■	■	■	■
San Joaquin	■	■	■	■
San Mateo	■	■	■	■
Santa Clara	❍	■	■	■
Santa Cruz	■	■	■	■
Solano	■	❍	■	■
Sonoma	❍		■	■
Stanislaus	■	❍	■	■
Tuolomne				■
Outside of California	Urgent/ER Care Only	Urgent/ER Care Only	Urgent/ER Care Only	No Service Area Limits

■ = Available in this county

❍ = Available in some zip codes; verify your zip code with the plan to confirm availability.

Blue Shield of California and Kaiser Permanente: Service Area Limits

You must reside in a zip code serviced by the plan. If you do not see your county listed above, contact the medical plan to see if service is available to you. For Blue Shield Trio HMO call (855) 747-5800. For Blue Shield of California Access+ HMO call (855) 256-9404. For Kaiser Permanente call (800) 464-4000.

City Plan PPO: No Service Area Limits

City Plan, administered by UnitedHealthcare, does not have any service area requirements. If you have questions, contact UnitedHealthcare at (866) 282-0125.

City Plan PPO: (HMO Choice Not Available)

Members who lack geographic access to other plans offered by SFHSS (Blue Shield of California or Kaiser Permanente) are eligible to enroll in City Plan–Choice Not Available with lower premiums.

Change of Address: Notify SFHSS

If you move out of the service area covered by your plan, you must elect an alternate medical plan that provides coverage in your area. Failure to change your health benefit elections may result in the non-payment of claims for services received. Contact the San Francisco Health Service System at (415) 554-1750 to update your information and review plan options if you are changing your address.

2019 Medical Plans

To enroll in Kaiser Permanente or Blue Shield of California, you must live or work in a zip code serviced by the plan. Contact the medical plan if you have questions about covered service areas. City Plan (UHC) PPO does not have service area requirements.

This chart provides a summary of benefits. In the instance where information in this chart conflicts with the plan's Evidence of Coverage, the plan's Evidence of Coverage shall prevail. For a detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage (EOC), available on sfhss.org.

	BLUE SHIELD HMO		KAISER PERMANENTE HMO	CITY PLAN PPO	
	TRIO HMO	ACCESS+ HMO	TRADITIONAL PLAN	UNITEDHEALTHCARE	
Choice of Physician	Primary Physician assignment required.	Primary Physician assignment required.	Kaiser network only. Primary Care Physician assignment required.	You may use any licensed provider. You receive a higher level of benefit and pay lower out-of-pocket costs when choosing in-network providers.	
Deductible	No deductible		No deductible	IN-NETWORK AND OUT-OF-AREA $250 employee only $500 + 1 $750 + 2 or more	OUT-OF-NETWORK $500 employee only $1,000 + 1 $1,500 + 2 or more
Out-of-Pocket Maximum does not include premium contributions	$2,000 per individual $4,000 per family		$1,500 per individual $3,000 per family	$3,750 per individual $12,700 per family	$7,500 per individual
General Care and Urgent Care					
Routine Physical; Well Woman Exam	No charge		No charge	100% covered no deductible	50% covered after deductible
Doctor's Office Visit	$25 co-pay		$20 co-pay	85% covered after deductible	50% covered after deductible
Urgent Care Visit	$25 co-pay in-network		$20 co-pay	85% covered after deductible	50% covered after deductible
Family Planning	No charge		No charge	100% covered no deductible	50% covered after deductible
Immunizations	No charge		No charge	100% covered no deductible	50% covered after deductible
Lab and X-ray	No charge		No charge	85% covered after deductible & prior notification	50% covered after deductible & prior notification
Doctor's Hospital Visit	No charge		No charge	85% covered after deductible	50% covered after deductible
Prescription Drugs					
Pharmacy: Generic	$10 co-pay 30-day supply		$5 co-pay 30-day supply	$10 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply
Pharmacy: Brand-Name	$25 co-pay 30-day supply		$15 co-pay 30-day supply	$25 co-pay 30-day supply	50% covered after $20 co-pay; 30-day supply
Pharmacy: Non-Formulary	$50 co-pay 30-day supply		Physician authorized only	$50 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply
Mail Order: Generic	$20 co-pay 90-day supply		$10 co-pay 100-day supply	$20 co-pay 90-day supply	Not covered
Mail Order: Brand-Name	$50 co-pay 90-day supply		$30 co-pay 100-day supply	$50 co-pay 90-day supply	Not covered
Mail Order: Non-Formulary	$100 co-pay 90-day supply		Physician authorized only	$100 co-pay 90-day supply	Not covered
Specialty	20% up to $100 co-pay; 30-day supply		20% up to $100 co-pay 30-day supply	Same as 30-day above limitations apply; see EOC	Same as 30-day above limitations apply; see EOC

2019 Medical Plans

	BLUE SHIELD HMO		KAISER PERMANENTE HMO	CITY PLAN PPO	
				UNITEDHEALTHCARE	
	TRIO HMO	ACCESS+ HMO	TRADITIONAL PLAN IN-NETWORK ONLY	IN-NETWORK AND OUT-OF-AREA	OUT-OF-NETWORK
Hospital Outpatient and Inpatient					
Hospital Outpatient	$100 co-pay per surgery		$35 co-pay	85% covered after deductible	50% covered after deductible
Hospital Inpatient	$200 co-pay per admission		$100 co-pay per admission	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification
Hospital Emergency Room	$100 co-pay waived if hospitalized		$100 co-pay waived if hospitalized	85% covered after deductible if non-emergency, 50% after deductible	85% covered after deductible if non-emergency, 50% after deductible
Skilled Nursing Facility	No charge 100 days per plan year		No charge 100 days per benefit period	85% covered after deductible; 120 days per plan year; limits apply	50% covered after deductible; 120 days per plan year; limits apply
Hospice	No charge authorization required		No charge when medically necessary	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Maternity and Infertility					
Hospital or Birthing Center	$200 co-pay per admission		$100 co-pay per admission	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification
Pre-/Post-Partum Care	No charge		No charge	85% covered after deductible	50% covered after deductible
Well Child Care	No charge must enroll newborn within 30 days of birth; see EOC		No charge must enroll newborn within 30 days of birth; see EOC	100% covered no deductible	100% covered no deductible
IVF, GIFT, ZIFT and Artificial Insemination	50% covered limitations apply; see EOC		50% covered limitations apply; see EOC	50% covered after deductible; limitations apply; prior notification	50% covered after deductible; limitations apply; prior notification
Mental Health and Substance Abuse					
Outpatient Treatment	$25 co-pay non-severe and severe		$10 co-pay group $20 co-pay individual	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Inpatient Facility including detox and residential rehab	$200 co-pay per admission		$100 co-pay per admission	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Other					
Hearing Aids 1 aid per ear every 36 months, evaluation no charge	Up to $2,500 each		Up to $2,500 each	85% covered after deductible; up to $2,500 each	50% covered after deductible; up to $2,500 each
Medical Equipment, Prosthetics and Orthotics	No charge as authorized by PCP		No charge as authorized by PCP	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Physical and Occupational Therapy	$25 co-pay		$20 co-pay authorization required	85% covered after deductible; 60 visits max per plan year	50% covered after deductible; 60 visits max per plan year
Acupuncture/ Chiropractic	$15 co-pay 30 visits max for each per plan year; ASH network		$15 co-pay up to a combined total of 30 chiropractic and acupuncture visits/year; ASH network	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year
Gender Dysphoria office visits and outpatient surgery	Co-pays apply authorization required		Co-pays apply authorization required	85% covered after deductible; prior notification	50% covered after deductible; prior notification

2019 Bi-Weekly Medical Premium Contribution Rates

Medical: Employee Only

	BLUE SHIELD OF CALIFORNIA TRIO HMO		BLUE SHIELD OF CALIFORNIA ACCESS+ HMO		KAISER PERMANENTE HMO		CITY PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Superior Court Employees Local 21	$345.07	$0.00	$402.74	$0.00	$282.21	$0.00	$497.22	$0.00
Superior Court Employees Local 1021								
Superior Court Judges								
Superior Court Reporters								
Superior Court Staff Attorneys								
Superior Court Staff Attorneys Cash Back[1]								
Superior Court Interpreters								
Superior Court Unrepresented Professionals								

Medical: Plus One

	BLUE SHIELD OF CALIFORNIA TRIO HMO		BLUE SHIELD OF CALIFORNIA ACCESS+ HMO		KAISER PERMANENTE HMO		CITY PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Superior Court Employees Local 21	$688.36	$0.00	$803.72	$0.00	$562.51	$0.00	$962.26	$0.00
Superior Court Employees Local 1021								
Superior Court Judges								
Superior Court Reporters								
Superior Court Staff Attorneys								
Superior Court Staff Attorneys Cash Back[1]								
Superior Court Interpreters								
Superior Court Unrepresented Professionals								

Medical: Plus Two or More

	BLUE SHIELD OF CALIFORNIA TRIO HMO		BLUE SHIELD OF CALIFORNIA ACCESS+ HMO		KAISER PERMANENTE HMO		CITY PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Superior Court Employees Local 21	$973.31	$0.00	$1,136.54	$0.00	$795.16	$0.00	$1,137.00	$215.02
Superior Court Employees Local 1021								
Superior Court Judges								
Superior Court Reporters								
Superior Court Staff Attorneys								
Superior Court Staff Attorneys Cash Back[1]			$1,040.08	$96.46			$1,040.08	$311.94
Superior Court Interpreters			$1,136.54	$0.00			$1,137.00	$215.02
Superior Court Unrepresented Professionals								

[1]Attorneys with enrolled dependents who wish to elect the cashback rate must complete additional forms. Contact SFHSS for details.

Preventive Care

If Everyone in the United States Received Recommended Clinical Preventive Care, We Could Save 100,000 Lives Each Year[1]

Most preventive care services are covered 100%, at no cost to you. Preventive care services include regular checkups, screenings, vaccinations and healthy lifestyle programs. Preventive care and healthy lifestyle choices are small steps that can improve your well-being. With appropriate preventive care, you may avoid or delay the onset of a condition. An early diagnosis may increase the probability that treatment will be effective. Members who receive appropriate preventive care also help our entire health benefits system to manage costs for current and future members, particularly as we transition from active employees to retirees.

Get Started With Your Preventive Care

1. Go to cdc.gov/prevention to receive a personalized list of recommended preventive care.

2. Contact your health care provider to schedule your preventive care and learn about services they offer to help you live a healthy lifestyle. **Also, don't forget to take care of your teeth and eyes with routine dental and vision checkups.**

3. Explore new ways of managing stress, eating healthy, managing your weight and adopting healthy behaviors that support your total good health and well-being. See sfhss.org/well-being for programs and information available to you as an SFHSS member.

Tobacco Cessation Resources

Blue Shield Trio HMO and Access+ HMO	Kaiser Permanente HMO	UnitedHealthcare City Plan PPO
QuitNet QuitNet offers a dynamic tobacco cessation program with daily email or text support. To get started with QuitNet, login to mywellvolution.com and click on the QuickNet program. QuitNet is based on the latest science and best practices to help people overcome their addiction to tobacco. QuitNet combines many intervention methods, including online and mobile support from experts and peers, phone-based coaching from a tobacco treatment specialist, personalized email and text support, and pharmaceutical quit aids.	You may be eligible to receive tobacco cessation medications at your drug-benefit co-payment price with a prescription from your doctor. Kaiser Permanente also offers face-to face individual tobacco cessation counseling or classes, or sign up online for a Freedom from Tobacco class at a location near you at kp.org. **Breathe** is an online personalized program which supports you as you explore why it's hard to quit smoking, offering tips and advice to help you give up the habit. Go to kp.org/breathe to get started.	UnitedHealthcare (UHC) covers smoking cessation prescriptions from an in-network pharmacy, at no cost to member, as Preventive. Online tools: liveandworkwell.com also includes a tobacco cessation website where members can view a list of resources and support ideas. Once you login, click on "Mind and Body," where you will find self-management tools for smoking cessation, assessments and screeners and cost estimators demonstrating the money that could be saved by quitting smoking. Face-to-face: If you use tobacco, we cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you.

[1] *https://www.cdc.gov/prevention/index.html*

2019 Vision Plan Benefits

All SFHSS members and dependents who are enrolled in an SFHSS medical plan are automatically enrolled in vision benefits.

Vision Plan Benefits

SFHSS members and dependents enrolled in a medical plan administered by SFHSS have vision coverage through VSP Vision Care. You may use a VSP Vision Care network doctor or a non-VSP doctor. To locate a VSP network doctor, visit vsp.com or contact Member Services at (800) 877-7195.

Accessing Your Vision Benefits

No ID cards are issued for the vision plan. To receive service from a VSP Vision Care network doctor, contact the doctor, identify yourself as a VSP Vision Care member and make an appointment. VSP Vision Care will provide benefit authorization to the doctor. Services must be received prior to the benefit authorization expiration date.

If you receive services from a VSP Vision Care network doctor without prior authorization, or obtain services from a vision care service provider outside of the VSP Vision Care network (including Kaiser Permanente), you are responsible for payment in full to the provider. You may then submit an itemized bill directly to VSP Vision Care for partial reimbursement. Compare the costs of out-of-network vision services to VSP Vision Care in-network costs before choosing. Download claim forms at vsp.com.

Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every other calendar year unless enrolled in the Premier Plan. If examination reveals prescription change of 0.50 diopter or more after 12 months, replacement lenses covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, will cost you more.

Vision Plan Expenses Not Covered

- Orthoptics or vision training and any associated supplemental testing, plano (non-prescription) lenses or two pairs of glasses in lieu of bifocals.
- Replacement of lenses or frames furnished under this plan that are lost or broken, except at the contracted intervals.
- Medical or surgical treatment of the eyes, except for limited acute eye care described below.
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. You may be eligible for discounts from a VSP Vision Care doctor.

VSP Basic and Premier Vision Plans

You now have choices—as a new hire or during open enrollment you can stay enrolled in the Basic Plan or choose the Premier Plan for enhanced benefits, such as a $300 allowance on frames or a $250 allowance on contacts lenses every calendar year. Anti-reflective are covered in full with a $25 co-pay for each. Starting on July 1, 2018, standard progressive lenses will be covered at 100%, with co-pays for premium and custom progressive lenses. See page 15 for details.

Computer Vision Care Benefit (VDT)

Some union contracts provide employer-paid computer vision (VDT) benefits. Coverage includes an annual computer vision exam, $75 in-network retail frame allowance every 24 months and single vision, lined bifocal, lined trifocal lenses.

VSP Vision Care Member Extras

VSP Vision Care offers exclusive special offers and discounts, including an extra $20 on featured frame brands, and rebates on popular contact lenses. VSP also provides savings on hearing aids through TruHearing® for you, covered dependents and extended family including parents and grandparents.

No Medical Plan, No Vision Benefits

If you do not enroll in a medical plan, you and your dependents cannot access VSP Vision Care benefits.

Superior Court Employees

2019 Vision Plan Benefits-at-a-Glance

Covered Services	Basic	Premier
Well Vision Exam	$10 co-pay every calendar year	$10 co-pay every calendar year
Single Vision Lenses Lined Bifocal Lenses Lined Trifocal Lenses	$25 co-pay every other calendar year[1] $25 co-pay every other calendar year[1] $25 co-pay every other calendar year[1]	$0 every calendar year $0 every calendar year $0 every calendar year
Standard Progressive Lenses Premium Progressive Lenses Custom Progressive Lenses	100% coverage every other calendar year $95–$105 co-pay every other calendar year $150–$175 co-pay every other calendar year	100% coverage every calendar year $25 co-pay every calendar year $25 co-pay every calendar year
Standard Anti-Reflective Coating Premium Anti-Reflective Coating Custom Anti-Reflective Coating	$41 co-pay every other calendar year $58–$69 co-pay every other calendar year $85 co-pay every other calendar year	$25 co-pay every calendar year $25 co-pay every calendar year $25 co-pay every calendar year
Scratch-Resistant Coating	Fully covered every other calendar year	Fully Covered every calendar year
Frames	$150 allowance for a wide selection of frames $170 allowance for featured frames $80 allowance use at Costco® $25 co-pay applies; 20% savings on amount over the allowance; every other calendar year	$300 allowance for a wide selection of frames $320 allowance for featured frames $165 allowance at Costco® No additional co-pay; 20% savings on the amount over your allowance every calendar year
Contacts (instead of glasses)	$150 allowance every other calendar year[1]	$250 allowance every calendar year
Contact Lens Exam	Up to $60 co-pay every other calendar year[1]	Up to $60 co-pay every calendar year
Primary Eye Care (for the treatment of urgent or acute ocular conditions)	$5 co-pay	$5 co-pay
Vision Care Discounts		
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities
	Employee Contribution	**Employee Biweekly Contribution**
	Included in medical premium	Employee Only $4.32 Employee + 1 Dependent $6.48 Employee + Family $13.53

Your Coverage with Out-of-Network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

Exam	Up to $50	Single Vision Lenses	Up to $45	Lined Trifocal Lenses	Up to $85	Contacts	Up to $105
Frame	Up to $70	Lined Bifocal Lenses	Up to $65	Progressive Lenses	Up to $85		

[1] With the Basic Plan, new eyeglass lenses may be covered the next year if Rx change is more than .50 diopters. Based on your last date of service.

In the instance where information in this chart conflicts with the plan's Evidence of Coverage (EOC), the plan's EOC shall prevail.

NOTE: IFPTE Local 21, SEIU 1021 and miscellaneous unrepresented employees are also eligible for VDT Computer VisionCare benefits.

Superior Court Employees

2019 Biweekly VSP Premier Contribution Rates

	VSP Premier
	Employee Pays
Employee Only	**$4.32**
Employee + 1 Dependent	**$6.48**
Employee + 2 or More Dependents	**$13.53**

2019 Dental Plan Benefits

Dental benefits are an important and valuable part of your healthcare coverage and key to your overall health.

Delta Dental PPO's *SmileWay* program features 100% coverage for one annual periodontal scaling and root planing procedure and an increased number of teeth cleaning or periodontal maintenance services for members with specific chronic conditions. Additionally, adult orthodontic lifetime maximums have increased and Dental Accident Benefits have been added to provide additional coverage for dental services for conditions caused directly or independently of all other causes by external, violent, and accidental means.

PPO-Style Dental Plans

A PPO-style dental plan allows you to visit any in-network or out-of-network dentist. The plan pays higher benefits (and you pay less) when you visit an in-network PPO dentist.

SFHSS offers the following PPO-style dental plan:

- Delta Dental PPO

If You Enroll in Delta Dental, Save Money By Choosing PPO Dentists

The Delta Dental plan has two different networks. Ask your dentist if they are a Delta Dental PPO network or Premier network dentist. Both networks are held to the same quality standards. Choosing a PPO dentist will save you money. You can also choose a dentist outside of the PPO and Premier networks. However, many services may be covered at a lower percentage, so you pay more. Also, payment is based on reasonable and customary fees for the geographic area.

Ask your Delta Dental dentist about costs before receiving services. You can request a pre-treatment estimate of costs before you receive care. For more information call Delta Dental at (888) 335-8227.

DHMO-Style Dental Plans

Similar to medical HMOs, Dental Health Maintenance Organization-style (DHMO-style) plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally smaller than a dental PPO network. Before you elect a DHMO-style plan, make sure that the plan's network includes the dentist of your choice.

Under these plans, services are covered either at no cost or a fixed co-pay. So there are generally lower out-of-pocket costs for these plans compared to the PPO dental plan.

SFHSS offers the following DHMO-style plans:

- DeltaCare USA
- UnitedHealthcare Dental

Dental Plan Quick Comparison

	Delta Dental PPO	DeltaCare USA DHMO-style	UnitedHealthcare Dental DHMO
Can I receive service from any dentist?	Yes. You can use any dental provider. You pay less when you choose a PPO in-network provider.	No. All services must be received from your assigned contracted network dentist.	No. All services must be received from a contracted network dentist.
Do I need a referral for specialty dental care?	No.	Yes.	Yes.
Will I pay a flat rate for most services?	No. You pay a percentage of allowed charges.	Yes.	Yes.
Must I live in a certain service area to enroll?	No.	Yes. You must live in this plan's service area.	Yes. You must live in this DHMO's service area.

2019 Dental Plan Benefits-at-a-Glance

	Delta Dental PPO			DeltaCare USA DHMO-style	United Healthcare Dental DHMO
Choice of dentist	You may choose any licensed dentist. You will receive a higher level of benefit and lower out-of-pocket costs when using a Delta Dental PPO network dentist.			DeltaCare dental network only	UnitedHealthcare dental network only
Deductible	None			None	None
Plan year maximum	$2,500 per person Per year, excluding orthodontia benefits			None	None
Covered Services	**PPO Dentists**	**Premier Dentists**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Cleanings and exams	100% covered 2x/yr; pregnancy 3x/yr; chronic condition 4x/yr[1] (new)	100% covered 2x/yr; pregnancy 3x/yr; chronic condition 4x/yr[1] (new)	80% covered 2x/yr; pregnancy 3x/yr; chronic condition 4x/yr[1] (new)	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	100% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	80% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	100% covered some limitations apply	100% covered
Extractions	90% covered	80% covered	60% covered	100% covered	100% covered
Fillings	90% covered	80% covered	60% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Crowns	90% covered	80% covered	50% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Dentures, pontics and bridges	50% covered	50% covered	50% covered	100% covered Full and partial dentures 1x/5 years; fixed bridgework, limitations apply	100% covered Full and partial dentures 1x/5 years; fixed bridgework, limitations apply
Endodontic/ Root Canals	90% covered	80% covered	60% covered	100% covered Excluding the final restoration	100% covered
Oral surgery	90% covered	80% covered	60% covered	100% covered	100% covered
Implants	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	Not covered	Covered Refer to co-pay schedule
Orthodontia	50% covered child $2,500 lifetime max; adult $2,500 lifetime max	50% covered child $2,000 lifetime max; adult $2,000 lifetime max	50% covered child $1,500 lifetime max; adult $1,500 lifetime max	Employee pays: $1,600/child $1,800/adult $350 startup fee; limitations apply	Employee pays: $1,250/child $1,250/adult $350 startup fee; limitations apply
Night Guards	80% covered (1x3yr)	80% covered (1x3yr)	80% covered (1x3yr)	$100 copayment	100% covered

This chart provides a summary of benefits. It is not a contract. For a more detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage (EOC), available on sfhss.org.

[1] Chronic Conditions are diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and/or stroke.

Superior Court Employees

2019 Biweekly Dental Premium Contribution Rates

	DELTA DENTAL PPO		DELTACARE USA DHMO-Style		UNITEDHEALTHCARE DENTAL DHMO	
SUPERIOR COURT	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Employee Only	**$27.91**	**$0**	**$12.44**	**$0**	**$12.83**	**$0**
Employee + 1 Dependent	**$58.62**	**$0**	**$20.52**	**$0**	**$21.18**	**$0**
Employee + 2 or More Dependents	**$83.74**	**$0**	**$30.35**	**$0**	**$31.32**	**$0**

Flexible Spending Accounts (FSAs)

An FSA account can pay qualifying expenses incurred by you, your legal spouse or qualifying child or relative (as defined in Internal Revenue Code Section 152). You can enroll in either a Healthcare FSA, a Dependent Care FSA, or both. FSAs are administered by P&A Group; visit padmin.com or *Key Contacts* on page 37 for more information.

FSA enrollment is required each year. You must re-enroll in Flexible Spending Account(s) every Open Enrollment if you want to continue this benefit for the next plan year. If you do not re-enroll, your FSA will terminate at the end of the plan year.

If you are enrolled in an FSA and go on a leave of absence, you must contact the San Francisco Health Service System. Taking a leave of absence will affect your FSA contributions and reimbursement periods.[1]

Healthcare FSA with Carryover

A **Healthcare FSA** can help pay for medical expenses. This includes medical, pharmacy, dental and vision co-payments, other dental and vision care expenses, acupuncture and chiropractic care, doctor-approved weight loss programs and more. For a complete list of eligible healthcare expenses, visit padmin.com.

- Set aside between $250 and $2,650 pre-tax per employee for the plan year. Depending on the amount you elect, deductions between $10 and $106 will be taken biweekly from your paycheck January–December 2019.
- P&A will issue a debit card for you to use to make spending your FSA easier or you can submit a claim by mail, online or SmartPhone.
- SFHSS administers a Carryover minimum of $10 and maximum of $500. At the end of the plan year claim filing period, unreimbursed Healthcare FSA funds below $10 and over $500 will be forfeited.
- Carryover fund amounts between $10 and $500 are determined after the end of the claim filing period and are then available for any claims incurred as of the first day of the new plan year. Carryover funds can only be accessed for one plan year. After one plan year, remaining Carryover funds will be forfeited. There are no exceptions.[2]

Childcare/Eldercare Dependent Care FSA

A **Dependent Care FSA** can help pay for qualifying child care and elder care expenses, such as certified children's day care, pre-school, day camp, before/after school programs, as well as adult day care for elders. Dependent care expenses must be incurred to enable you (and, if married, your spouse) to work. Children must be under age 13. For a complete list of eligible dependent care expenses, visit padmin.com.

- Set aside between $250 and $5,000 pre-tax per household for the plan year. ($2,500 each if you are married filing separate federal tax returns.) Depending on the amount you elect, deductions between $10 and $200 will be taken biweekly from your paycheck in 2019.
- Funds for a Dependent Care FSA *cannot be used for dependent medical, dental, or vision expenses*. If you have a stay-at-home spouse, you cannot enroll in a Dependent Care FSA.
- Submit reimbursement documentation to P&A Group by mail, online, or by smartphone app for eligible out-of-pocket expenses.
- Funds for a Dependent Care FSA are available after being deducted from your paycheck and received by the plan administrator. The entire annual amount for a Dependent Care FSA is not available January 1, 2019.
- Funds for a Dependent Care FSA must be used for incurred qualifying expenses during the plan year or be forfeited. There are no exceptions.[2] **Unlike a Healthcare FSA, there is no Carryover option.**

[1] For complete information about FSA benefits and guidelines, please see the *2019 P&A Flexible Spending Accounts* brochure available for download at sfhss.org.

[2] FSA expenses for the 2019 plan year must be incurred in 2019 and received by P&A no later than March 31, 2020. Per IRS rules, you forfeit all funds remaining in an FSA by the end of the claim filing period *unless* they are covered by the Healthcare FSA Carryover provision. There are no exceptions.

Voluntary Benefits

These optional insurance plans can help protect you and your family.

SFHSS has partnered with WORKTERRA (EBS) to offer quality insurance plans at the best cost:

- Plans are reviewed and approved by San Francisco Health Service System
- In most cases, guaranteed issue so no medical history or exam required
- Discounted group premium rates
- Optional enrollment - if you choose to enroll, premiums can be paid by payroll deduction

Aetna Life Group Term Life Insurance provides a lump sum benefit to your designated beneficiary if you die. It can help your loved ones pay for funeral expenses. It can also shield them from the loss of your income, by helping pay a mortgage, debts, college tuition and other living expenses. Completion of an application with evidence of insurability (i.e. medical history questions) is required for coverage during this open enrollment. Guaranteed Issue is available for up to $100,000 for new hires and up to $50,000 for their spouse/domestic partner. Higher policy amounts are available, which require additional medical certification.

Kansas City Life Short Term Disability Insurance replaces part of your income if you can't work due to a non-occupational covered illness or injury. It provides income in addition to California State Disability payments. This can help you and your family meet financial obligations until you get back to work. For employees only.

Voya Financial Accident Insurance provides tax-free payments for covered injuries that happen off the job. Benefits paid directly to you, to help pay for out-of-pocket medical costs related to an injury, assist with living expenses, or anything else you choose. Available to employees and eligible dependents.

Voya Financial Critical Illness Insurance pays a lump sum benefit if you are diagnosed with a covered disease or condition, including heart attack, stroke and certain types of cancer. This can ease the financial stress of facing a life-threatening illness. This benefit can help pay for out-of-pocket medical costs related to the diagnosis, assist with living expenses, or anything else you choose. Available to employees and eligible dependents.

LifeLock Identity Theft Protection monitors and notifies you if your information is being used fraudulently in credit card applications, loans, mortgages and other digital data. The plan also provides identity restoration services and coverage up to $1,000,000 if you become a victim of identity theft. Available to employees and eligible dependents.

LegalShield Legal Plan allows you to speak with a lawyer on any personal legal matter without high hourly costs. Includes letters or calls made on your behalf, review of small contracts and documents, IRS audit support, assistance with preparing a Will, Living Will, and healthcare power of attorney. 24/7 emergency access is available for covered situations. LegalShield membership offers an optional identity theft plan. Available to employees and eligible dependents.

Pets Best Pet Insurance can reimburse you for vet bills when your cat or dog is sick or injured with a covered condition. Use any licensed veterinarian, pay your bill, then submit a claim for reimbursement. When enrolling you can choose coverage tiers from 70% to 90%, with deductible choices from $50 to $1,000. Available to employees.

To enroll in Voluntary Benefits online, go to workterra.net. Your user name is your employee DSW number (if DSW number is only 5-digits, add a "0" in front of number). Your password is the first four letters of your last name and the first four of your social security number. The company name is ccsf. See *Key Contacts* on page 37 for contact information.

Mental Health and Substance Abuse Benefits

As a result of federal mental health parity law, there is no yearly or lifetime dollar limit for essential mental health benefits. Also, deductibles, co-payments, coinsurance, out-of-pocket limits, number of days or visits covered and any pre-authorization of treatment must be the same for mental health and medical/surgical services. Employees can also access the Employee Assistance Program (EAP): (415) 554-0610. For urgent mental health issues, call 911 or go to the closest emergency department.

Blue Shield of California Trio HMO and Access+ HMO	Kaiser Permanente HMO	UnitedHealthcare City Plan PPO
Mental Health and Substance Abuse Services		
Call (877) 263-9952 to find a provider and schedule an appointment.	Call (800) 464-4000 to make an appointment or contact your Primary Care Physician or call (415) 833-2292. You don't need a referral to see a therapist. Make an appointment to see a therapist, without referral, through your Primary Care Physician.	Call (866) 282-0125 to make an appointment. Telemental Health: Services are available with participating providers. To find providers online, go to liveandworkwell.com or welcometouhc.com/sfhss.
Mental Well Being Services		
Counseling and Consultation: *LifeReferrals* is available with no co-payment. Topics include relationship problems, stress, grief, and community referrals. Legal and identity theft consultations also available. Call (800) 985-2405, 24/7. Online Coaching: Take well-being one day at a time with the *DailyChallenge at* mywellvolution.com.	Classes, Support Groups: Contact your local Kaiser Permanente facility for a calendar or visit kp.org/mentalhealth for more information. There are no co-payments for attending classes and support groups. Telephone/Online Coaching: Call (866) 862-4295 or visit kp.org and search for *HealthMedia Relax*.	Call the *Confidential Help* line 24/7 at (866) 282-0125. Telemental Health: Services are available with participating providers. To find providers online, go to liveandworkwell.com or welcometouhc.com/sfhss. Mental Health Providers and Online resources can be found at liveandworkwell.com. Members can also link to this directly from their myuhc.com profile.

Free, Confidential Counseling, and More through the SFHSS Employee Assistance Program (EAP)

EAP provides confidential, voluntary, free mental health services to all employees and immediate family members. EAP is staffed by licensed therapists. Services include:

- Short-term, solution-focused counseling for individual, couples, and families
- Critical incident debriefing and trauma response
- Mediation and conflict resolution

Appointments are available Monday through Friday, from 9:00am-5:00pm, call (415) 554-0610.

Resources and referral EAP services are confidential in accordance with state and federal law.

Best Doctors: Expert Medical Case Review

Expert physicians provide free and confidential case review when you or a family member faces any important medical decision.

Get an in-depth medical review by a world-renowned expert when concerned about a medical service or treatment plan. Consider using Best Doctors if you or a family member needs to:

- Confirm a diagnosis
- Decide if a recommended surgery is necessary
- Review a recommended treatment plan for a life-threatening illness like cancer or heart disease
- Learn more about a prescribed medication or medication interactions
- Evaluate options for treating chronic joint pain or back pain
- Manage a complex chronic condition, or multiple conditions

The Best Doctors benefit includes:

In-Depth Medical Case Review

At your request, Best Doctors collects and reviews your medical records, including images and tests. Expert physicians review your information and you receive a detailed report and a confidential recommendation about your diagnosis and treatment plan. Best Doctors will discuss this report with you and with your treating physician if you request it. This service helps you make the treatment decisions that are right for you.

Ask the Expert

If you have a basic question about a diagnosis or treatment options, you can obtain personalized guidance from a physician with specific expertise.

Critical Care

If you or your dependent family member is admitted to an emergency room with a traumatic injury requiring critical care or neonatal unit for an acute medical event, Best Doctors' emergency medical experts can provide early intervention along with your treating medical team. A nurse will be sent within two hours to review your care and coordinate with the Best Doctors' expert if needed to help make critical decisions.

Find a Doctor

Best Doctors can locate an in-network physician using their network of medical experts.

Medical Records eSummary

Best Doctors can collect and organize all your medical records along with a personal health summary from a Best Doctor and provide them to you on an easy-to-access USB drive.

Contact Best Doctors: To get started, call Best Doctors at (866) 904-0910, M-F, 5am-6pm PST, or visit *members.bestdoctors.com*. You will be assigned a Best Doctors clinician to help you through the process and to select the best option for you. With your permission, Best Doctors will gather and review your medical records, including images, lab results and pathology slides to make their recommendations.

Long-Term Disability Insurance (LTD)

Employer-paid LTD can replace lost income if you are injured or ill.

Employer-Paid Long Term Disability Insurance

Some union contracts provide for Long Term Disability Insurance. A long-term disability is an illness or injury that prevents you from working for an extended period of time. If you submit a long-term disability claim and it is approved, the LTD plan may replace part of your lost income by paying you directly on a monthly basis. LTD payments will be reduced if you qualify for other sources of income, such as workers' compensation or state disability benefits).

LTD coverage begins the first of the month following date of hire. You are eligible for LTD coverage if you:

- Have a union contract that provides for employer-paid LTD insurance.
- Are actively at work more than 20 hours per week at the time of disability.
- Are a temporary exempt employee and complete 1,040 work hours in one consecutive 12 month period. Coverage begins the first day of the following month after you complete 1,040 hours.

Leave of Absence and LTD Coverage

If you are not actively at work due to illness or injury, LTD coverage continues for 12 months from the start of your approved medical leave. If your coverage terminates during a period of disability which began while you had coverage, benefits will be available as long as your period of disability continues.

If you are not actively at work due to non-medical reasons, such as personal leave, family care leave, or administrative leave, LTD coverage terminates at the end of the month following the month your absence began. Call SFHSS at (415) 554-1750 for information about LTD coverage.

Returning To Work

LTD programs can help you get back on the job when it's medically safe for you to do so. You may be able to return to work part-time, or work at a different type of job. If you qualify, LTD can continue paying a portion of your benefits.

Bargaining Units Covered by LTD

180-day elimination period; up to 60% of monthly base earnings; $5,000 monthly maximum:

Superior Court Clerical/Technical
SEIU Local 1021

90-day elimination period; up to 66.6667% of monthly base earnings; $7,500 monthly maximum:

Superior Court Attorneys Local 21 (311C, 312C, 316C)

Superior Court Professional Classes Local 21 (353C, 354C, 355C, 372C, 375C, 0648, 0649, 0655, 0676, 476C, 479C, 495C)
Superior Court Reporters Reporters Local 21

Superior Court Unrepresented Professional Classes (315C, 351C, 352C, 370C, 373C, 374C, 376C, 377C, 378C, 381C)

If your bargaining unit is not listed above you are not eligible for LTD benefits. This is a general summary. For LTD coverage details, see plan documents on sfhss.org or call Aetna at (866) 326-1380.

Group Life Insurance

Some union contracts provide employer-paid life insurance.

Employer-Paid Group Life Insurance

Life insurance offers your loved ones basic financial protection if you die. It can help pay your final expenses or help those you leave behind pay bills, like a mortgage or college tuition.

You are eligible for employer-paid life insurance if you:

- Have a union contract that provides for employer-paid life insurance coverage.
- Are actively at work.
- Coverage begins the first day of the month following your date of hire.

Life Insurance Beneficiaries

A beneficiary is the person or entity who receives the life insurance payment when the insured person dies. You may designate multiple beneficiaries. It is your responsibility to keep your beneficiary designations current. To update beneficiary designations, complete the Change Beneficiary Form and return to SFHSS: sfhss.org/benefits/ccsf_other_benefits.html.

Leaves of Absence

If you are not actively at work due to a temporary lay-off, personal leave, family care leave, or administrative leave (non-medical reasons), your coverage will terminate at the end of the month following the month your absence started.

If you are not actively at work due to illness or injury, your life insurance coverage will continue for 18 months from the start of your absence for medical reasons. After six months, you may qualify for a further extension of your life insurance benefits (Permanent and Total Disability Benefit); however, you must provide Aetna with a written notice of claim for this extended benefits within the 18-month coverage period. Call SFHSS at (415) 554-1750 for information about how a leave of absence can impact your life insurance coverage.

Outline of Life Insurance Plan Basics

Bargaining Unit	Coverage
Superior Court Attorneys 311C, 312C, 316C	$125,000
Superior Court Reporters Superior Court Local 21 Superior Court Misc. Unrepresented	$50,000
Superior Court SEIU Local 1021 Superior Court Interpreters	$25,000

If your bargaining unit is not listed above, you do not have employer-paid group life insurance.

Life Insurance Benefits Change Over Time

When you reach age 65, your benefits will drop to 65% of the original coverage amount. At age 70, your benefits will drop to 50%. At age 75, your benefits will drop to 30%.

Facing a Terminal Illness

If you are diagnosed with a terminal illness, you may request an Accelerated Death Benefit payment which pays you up to 75% of your life insurance coverage if you have 24 months or less to live. Also, Aetna Life Essentials offers no cost legal assistance for preparation of a living will or power of attorney, funeral planning and phone counseling by a licensed social worker. Visit aetna.com/aetnalifeessentials or contact Aetna Care Advocacy at (800) 276-5120.

Portability

If you leave your job or otherwise lose eligibility, you can convert your group life coverage to an individual policy, but you must pay life insurance premiums.

Additional Voluntary Benefits

To purchase additional life insurance or if you are not eligible for employer-paid life insurance, see page 21 to learn about Voluntary Benefits.

This is a general summary. For Group Life Insurance details see your plan documents on sfhss.org or call Aetna at (800) 523-5065.

Health Benefits During a Paid or Unpaid Leave of Absence

Medical, Dental and Vision

While you are on an unpaid leave, the Court continues employer contributions for your health benefits for a period of time in accordance with state and federal laws and your union contract. If you have employee contributions and you are not getting a check from the Court, please contact SFHSS **within 30 days** of when leave begins to either waive coverage or arrange for payment of premiums. Failure to do so can result in the termination of your health benefits, which may not be reinstated until you return to work or during Open Enrollment. When you return to work, contact SFHSS immediately (**within 30 days**) to request that health premium payroll deductions be returned to active status.

Healthcare FSA

During an unpaid leave, no FSA payroll deductions can be taken. To maintain your FSA, you must pay FSA contributions directly to SFHSS. Contact SFHSS **within 30 days** of when leave begins to arrange for payment of FSA contributions. You may suspend your Healthcare FSA if you notify SFHSS at the beginning of your leave. Accounts that remain unpaid for three consecutive pay periods will be suspended retroactively to the first missed pay period. Your Healthcare FSA will be reinstated once you return to work. If you want to maintain your annual election amount for expenses incurred before and after your leave, you must notify SFHSS **within 30 days** of your return to work. Your payroll deductions will be increased and spread proportionally over the remaining pay periods in the Plan Year. If you do not contact SFHSS, your annual election amount will be reduced by the amount of contributions missed (if any) during your leave of absence.

Dependent Care FSA

A Dependent Care FSA must be suspended while you are on leave. Claims incurred during leave are not reimbursable. To reinstate, you must notify SFHSS **within 30 days** of your return to work. Reinstatement of a Dependent Care FSA is only allowed on a go-forward basis. You may reinstate at the original biweekly FSA deduction amount, or you can increase biweekly deductions for the plan year. If you increase deductions, total FSA contributions for the year must equal and cannot exceed, the amount designated during Open Enrollment. If you do not notify SFHSS **within 30 days** of your return to work and request reinstatement of your FSA payroll deduction, FSA(s) will be canceled for the remainder of the plan year. There are no exceptions. If you return to work after December 2019, a suspended Healthcare or Dependent Care FSA initiated during the 2019 plan year cannot be reinstated. There are no exceptions.

Group Life Insurance

If you go on an approved leave due to illness or injury, employer-paid group life coverage continues for up to 18 months. For other types of leave, group life coverage ends the last day of the month after the month in which your leave begins. Group life insurance resumes the first day of the coverage period after you officially return to work.

Long-Term Disability (LTD) Insurance

If you go on an approved leave due to illness or injury, employer-paid long term disability coverage continues for up to 12 months. For other types of leave, LTD coverage ends the last day of the month after the month in which your leave begins. LTD coverage resumes the first day of the coverage period after you officially return to work.

Domestic Partner Imputed Income

If you have a domestic partner enrolled on your health coverage while you are on unpaid leave, you will have a catch-up payroll deduction for taxation related to imputed income when you return from leave.

Questions About Health Benefits During a Leave

If you have questions about health benefits during a leave of absence, call the Court's Integrated Disability Program Analyst at (415) 551-5964.

Transition to Retirement

Enrollment in Retiree Benefits Does Not Happen Automatically

The transition of health benefits from active to retiree status does not happen automatically. If eligible, you must elect to continue retiree health coverage by submitting the retiree enrollment form and supporting documents to SFHSS. **Contact SFHSS three months before your retirement date** to learn about enrolling in retiree benefits. You are required to notify SFHSS of your retirement, even if you are not planning to elect SFHSS coverage on your retirement date.

A retiree must have been a member of SFHSS at some time during his or her active employment in order to be eligible for retiree health benefits. Other restrictions may apply.

Depending on your retirement date, there can be a gap between when active employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a gap in SFHSS coverage. Call SFHSS at (415) 554-1750 to review your options before deciding on your retirement date.

Medicare Enrollment Required for Medicare-eligible Retirees and Dependents

All retirees and dependents who are Medicare-eligible due to age or disability are required to enroll. Failure of a retired member or dependent to enroll in Medicare when eligible will result in penalties, limitations in retiree member coverage and the termination of retiree dependent coverage. Processing of Medicare eligibility takes at least three months.

Retiree Premium Contributions

If you choose to continue medical and/or dental coverage through SFHSS after you retire, your retiree premium contribution may be higher than your active employee contributions. As a retired member, you will also be required to pay for dental coverage. Costs will depend on your plan choices, number of dependents covered and your Medicare status. Health premium contributions will be taken from your pension check. If monthly premium contributions are greater than your pension check, you must contact SFHSS to make payment arrangements. Premium rates are subject to change every plan year.

Lump-Sum Pension Distribution Will Affect Retiree Premium Contributions

If you choose to take a lump-sum pension distribution, your retiree healthcare premium contributions will be unsubsidized and you will pay the full cost.

Active Employee Medicare Enrollment

If you are working and eligible for SFHSS health coverage at age 65 or older, you are not required to enroll in Medicare. Even though it is not required, you are eligible for Medicare at age 65 and can enroll if you choose. Some employees over age 65 choose to enroll in premium-free Medicare Part A while they are still working. If you enroll in Part A, you must contact the Social Security Administration and enroll in Medicare Part B three months before you retire or otherwise leave Court employment. If you are over age 65 and not enrolled in both Medicare Part A and Part B upon retirement, you may be charged penalties by the federal government and you will be enrolled in City Plan 20.

Married Spouse Medicare Enrollment

A spouse covered on an active employee's SFHSS plan is not required to enroll in Medicare until you retire. A Medicare-eligible spouse must have enrolled in Medicare to be covered on a retiree's health plan.

Domestic Partner Medicare Enrollment

A registered domestic partner of an employee who is eligible for Medicare must be enrolled in Medicare to qualify for SFHSS medical coverage. The federal government charges a premium for Medicare Part B and in some cases, for Part D. All Medicare premium payments must be paid to maintain continuous Medicare enrollment. A domestic partner who fails to enroll in Medicare Part B when first eligible may be charged Medicare late enrollment penalties.

Contact the Employee Assistance Program

Contact EAP at (800) 795-2351 before your retirement date to plan for a meaningful retirement. Address any emotional or psychological changes and make your retirement years be the best they can be.

It's Important to Plan as You Approach Retirement

City Charter provisions regarding retiree health benefits for employees hired after January 9, 2009.

Proposition B, approved by San Francisco voters in 2008, amended City Charter provisions relating to retiree health benefits.

To be eligible for retiree health benefits, employees hired after January 9, 2009 must have at least 5 years of credited service with a City employer: City and County of San Francisco, San Francisco Unified School District, San Francisco City College or San Francisco Superior Court. Other government employment is not credited.

Also under this Charter amendment, employees hired after January 9, 2009 must retire within 180 days of separation from employment to be eligible for retiree health benefits. That means an employee must have the credited service and the age required for retirement at the time of separation from service to qualify for retiree health benefits.

A surviving dependent may be eligible for retiree health benefits if a deceased employee had 10 or more years of credited service with City employers.

If eligible, different premium contribution rates apply for employees hired after January 9, 2009, based on years of credited service with the City employers.

- **With at least 5 years but less than 10 years of credited service**, the retiree member must pay the full premium rate and does not receive any employer premium contribution.
- **With at least 10 years but less than 15 years of credited service,** the retiree will receive 50% of the total employer premium contribution.
- **With at least 15 years but less than 20 years of credited service**, the retiree will receive 75% of the total employer premium contribution.
- **With 20 or more years of credited service,** or disability retirement, the retiree will receive 100% of the total employer premium contribution.

Thinking About Retiring?

Make an informed decision. Confirm years of credited service with your retirement system: SFERS, CalPERS, CalSTRS or PARS. Note: There is no reciprocity with other public retirement systems under Proposition B for health benefits. Next, contact SFHSS. A benefits analyst will review your service credits, health benefits eligibility, retiree health plan options and premium contributions.

COBRA, Covered California and Holdover

COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), employees without holdover rights, or whose holdover rights have ended, may be eligible to continue medical, dental and vision coverage for themselves and eligible dependents at the employee's expense. Current year FSAs (Flexible Spending Accounts) may also be COBRA-eligible.

For Cobra information, visit padmin.com or call (800) 688-2611

Employees may elect to continue healthcare coverage through COBRA if coverage is lost due to:

- Voluntary or involuntary termination of employment (except for gross misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.

Covered spouses or domestic partners may also elect to be covered under COBRA if coverage is lost due to:

- Voluntary or involuntary termination of the employee's employment (except for misconduct).
- Divorce, legal separation, or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.
- Covered dependent children may elect COBRA.

Coverage if healthcare coverage is lost due to:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the employee employment (except for misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.
- Parent's divorce, legal separation, or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

COBRA Notification and Election Time Limits

If an employee and any enrolled dependents lose SFHSS coverage due to separation from employment, P&A Group will notify the employee of the opportunity to elect COBRA coverage. The employee or dependent has 60 days from the COBRA notification date to complete enrollment and continue coverage.

Coverage will be retroactive to the date of the COBRA-qualifying event, so there is no break in coverage. Employee coverage ends on the last day of the coverage period in which employment terminates. However, if the termination date falls on the first day of the coverage period, coverage ends that same day. If an enrolled dependent of an employee loses coverage due to divorce, dissolution of partnership, or aging out, the employee or the dependent must notify P&A Group within 30 days of the qualifying event and request COBRA enrollment information.

Paying for COBRA

It is the responsibility of covered individuals enrolled in COBRA to pay required healthcare premium payments directly to P&A Group. COBRA premiums are not subsidized by the employer.

Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

Duration of COBRA Continuation Coverage

COBRA coverage is generally available for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a coverage extension for up to 36 months. Employees and dependents who are eligible for less than 36 months of federal COBRA may also be eligible for Cal-COBRA. Continuation coverage under both federal and California state COBRA will not exceed 36 months.

Employees who are disabled on the date of their qualifying event, or any time during the first 60 days of COBRA coverage, are eligible for 29 months of coverage. Beginning the 19th month of coverage, the cost will rise to 150% of group rate.

2019 Monthly COBRA Premium Rates

Blue Shield of California Trio HMO	
Employee Only	$762.60
Employee +1	$1,521.28
Employee +2 or More	$2,151.02
Blue Shield of California Access+ HMO	
Employee Only	$890.06
Employee +1	$1,776.22
Employee +2 or More	$2,511.75
Kaiser Permanente HMO	
Employee Only	$623.68
Employee +1	$1,243.15
Employee +2 or More	$1,757.29
City Plan (United Healthcare) PPO	
Employee Only	$1,098.86
Employee +1	$2,126.60
Employee +2 or More	$2,987.96
Delta Dental PPO	
Employee Only	$61.69
Employee +1	$129.54
Employee +2 or More	$185.06
DeltaCare USA DHMO	
Employee Only	$27.49
Employee +1	$45.35
Employee +2 or More	$67.08
UnitedHealthcare Dental DHMO	
Employee Only	$28.36
Employee +1	$46.82
Employee +2 or More	$69.22
VSP Premier	
Employee Only	$9.55
Employee +1	$14.32
Employee +2 or More	$29.91

Flexible Spending Accounts and COBRA

To continue FSA benefits under COBRA, year-to-date FSA contributions must exceed year-to-date claims as of your employment termination date. To keep your FSA open, apply under COBRA and continue making the biweekly contribution plus a 2% administrative charge. COBRA Flexible Spending Account contributions are made post-tax.

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

- You obtain coverage under another group plan.
- You fail to pay the premium required under the plan within the grace period.
- The applicable COBRA period ends.

Covered California: Alternative to COBRA

Individuals who are not eligible for SFHSS coverage should consider obtaining health insurance through the state insurance exchange, Covered California. In some cases, you may qualify for tax credits and other assistance to make health insurance more affordable. For information about Covered California health plans, call (888) 975-1142 or visit coveredca.com.

Holdover Rights

Employees who are placed on a holdover roster may be eligible to continue SFHSS medical, dental and vision coverage for themselves and covered dependents. Eligibility requirements include:

Employees must certify annually that they are unable to obtain other health coverage.

Holdover premium contributions must be paid by the due date listed on the 2019 Health Coverage Calendar (see page 32). Rates may increase each plan year.

Health Service Board Achievements

Karen Breslin
President
Elected

Stephen Follansbee, MD
Vice President
Appointee

Sharon Ferrigno
Elected
Retiree

Wilfredo Lim
Elected
Employee

Rafael Mandelman
Board of
Supervisors

Randy Scott
Appointee
Commissioner

Steps to Improve and Maintain Affordable Benefits:

1. Through the Health Service Board Education Policy, the Board continues to be fully committed to being knowledgeable and apply understanding to business principles and practices of the San Francisco Health Service System and the Health System Trust.
2. Recruit and hire a new Executive Director for San Francisco Health Service System.

Benefit Additions:

The Health Service Board approved the following plan enhancements and benefits for 2019:

Flexible Spending Accounts (FSAs)

- Approved an increase to Health Flexible Spending Account (FSA) maximum from $2,500 to $2,650 for 2019.

VSP Basic and Premier Vision Plans

- Approved 100% coverage for standard progressive lenses for both Basic and Premier Vision Plan members.

Delta Dental PPO

- Approved SmileWay program allowing members diagnosed with chronic health conditions (diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and/or stroke) 100% coverage for one annual periodontal scaling and root planing procedure and up to four (any combination) teeth cleaning or periodontal maintenance services per year.
- Approved Adult orthodontic lifetime maximum increase by $1,000 in each provider tier category (to match child orthodontia maximum levels).
- Approved removal of six-month waiting period for prosthodontic and orthodontic coverage.
- Approved Cost Estimator Tool providing members the ability to model the estimated cost of specific dental services in advance and will suggest as an option, alternative, less-costly providers.
- Approved Accident Benefit Rider or additional coverage for dental services for conditions caused directly or independently of all other causes by external, violent, and accidental means.

City Plan PPO

- Approved new “City Plan PPO—HMO Choice Not Available” option providing lower member contributions for those who lack geographic access to other medical plans offered by SFHSS.
- Approved a provider re-contracting initiative increasing average discounts for provider services, without any change in provider composition of the PPO network.

UnitedHealthcare Medicare Advantage PPO

- Approved preferred diabetic supplies program.
- Approved reduction to member co-payments for kidney dialysis, urgent care and certain therapy services.
- Approved change to prescription drug formulary to better align with Medicare standards.
- Approved the Select Plus network for all California membership allowing for increased average network discounts for provider services allowing for greater discounts with no network disruption to the PPO network.
- Approved post-discharge meal delivery, care-related transportation (post-discharge and routine transportation), and nutritional counseling benefits.

2019 Health Coverage Calendar

Work Dates	Pay Date	Benefits Coverage Period
December 29, 2018–January 11, 2019	January 22, 2019	December 29, 2018–January 11, 2019
January 12, 2019–January 25, 2019	February 5, 2019	January 12, 2019–January 25, 2019
January 26, 2019–February 8, 2019	February 19, 2019	January 26, 2019–February 8, 2019
February 9, 2019–February 22, 2019	March 5, 2019	February 9, 2019–February 22, 2019
February 23, 2019–March 8, 2019	March 19, 2019	February 23, 2019–March 8, 2019
March 9, 2019–March 22, 2019	April 2, 2019	March 9, 2019–March 22, 2019
March 23, 2019–April 5, 2019	April 16, 2019	March 23, 2019–April 5, 2019
April 6, 2019–April 19, 2019	April 30, 2019	April 6, 2019–April 19, 2019
April 20, 2019–May 3, 2019	May 14, 2019	April 20, 2019–May 3, 2019
May 4, 2019–May 17, 2019	May 28, 2019	May 4, 2019–May 17, 2019
May 18, 2019–May 31, 2019	June 11, 2019	May 18, 2019–May 31, 2019
June 1, 2019–June 14, 2019	June 25, 2019	June 1, 2019–June 14, 2019
June 15, 2019–June 28, 2019	July 9, 2019	June 15, 2019–June 28, 2019
June 29, 2019–July 12, 2019	July 23, 2019	June 29, 2019–July 12, 2019
July 13, 2019–July 26, 2019	August 6, 2019	July 13, 2019–July 26, 2019
July 27, 2019–August 9, 2019	August 20, 2019	July 27, 2019–August 9, 2019
August 10, 2019–August 23, 2019	September 3, 2019	August 10, 2019–August 23, 2019
August 24, 2019–September 6, 2019	September 17, 2019	August 24, 2019–September 6, 2019
September 7, 2019–September 20, 2019	October 1, 2019	September 7, 2019–September 20, 2019
September 21, 2019–October 4, 2019	October 15, 2019	September 21, 2019–October 4, 2019
October 5, 2019–October 18, 2019	October 29, 2019	October 5, 2019–October 18, 2019
October 19, 2019–November 1, 2019	November 12, 2019	October 19, 2019–November 1, 2019
November 2, 2019–November 15, 2019	November 26, 2019	November 2, 2019–November 15, 2019
November 16, 2019–November 29, 2019	December 10, 2019	November 16, 2019–November 29, 2019
November 30, 2019–December 13, 2019	December 24, 2019	November 30, 2019–December 13, 2019
December 14, 2019–December 27, 2019	January 7, 2020	December 14, 2019–December 27, 2019

New Hires: Health Coverage Does Not Begin on Your Start-Work Date

You have 30 days from your start-work date to enroll in health benefits. If you enroll by the 30-day deadline, health coverage will begin on the first day of the coverage period following your start-work date.

Employee premium contributions are deducted from paychecks biweekly. Employee premium contributions for benefits coverage period are paid concurrent with the coverage period.

Flexible Spending Account (FSA) deductions will only occur on pay dates during the 2019 tax year.

If you take an approved unpaid leave of absence, you must pay SFHSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See page 26 for more information about maintaining health coverage during a leave of absence.

Legal Notices About Health Benefits

Notice of Medicare Part D Creditable Coverage

If you are Medicare-eligible and enrolled in a medical plan through the San Francisco Health Service System (SFHSS), your prescription drug coverage is better than the standard level of coverage set by the federal government under Medicare Part D. This qualifies as creditable coverage under Medicare Part D.

You only need to worry about this if in the future you or a Medicare-eligible dependent terminates or loses medical coverage administered through SFHSS. At that point this evidence of creditable coverage will prevent you from incurring penalties charged by the federal government for late enrollment in Medicare Part D. You must enroll in Medicare Part D no more than 62 days after your coverage through SFHSS terminates. Anyone who fails to act within that time period will incur a late enrollment penalty of at least 1% per month for each month after May 15, 2006 that the person did not have creditable coverage or enrollment in Part D.

For example, if 19 months passed between the time a person terminated creditable coverage with the SFHSS and enrollment in Medicare Part D, that person's Medicare Part D premium would always be at least 19% higher than what most other people pay. That person might also be required to wait until the following November when the federal government conducts Open Enrollment for Medicare in order to sign up for Medicare Part D prescription coverage.

If a person loses creditable prescription drug coverage through no fault of his or her own, that person may also be eligible for a Special Enrollment Period (SEP) to join a Medicare drug plan.

Women's Health and Cancer Rights Notice

The Women's Health and Cancer Rights Act of 1998 requires that your medical plan provide benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Contact your medical plan for details.

Use and Disclosure of Your Personal Health Information

SFHSS maintains policies to protect your personal health information in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA). Other than the uses listed below, SFHSS will not disclose your health information without your written authorization:

- To make or obtain payments from plan vendors contracted with SFHSS
- To facilitate administration of health insurance coverage and services for SFHSS members
- To assist actuaries in making projections and soliciting premium bids from health plans
- To provide you with information about health benefits and services
- When legally required to disclose information by federal, state, or local law (including Worker's Compensation regulations), law enforcement investigating a crime, and a court order or subpoena.
- To prevent a serious or imminent threat to individual or public health and safety.

If you authorize SFHSS to disclose your health information, you may revoke that authorization in writing at any time.

You have the right to express complaints to SFHSS and the Federal Health and Human Services Agency if you feel your privacy rights have been violated. Any privacy complaints made to SFHSS should be made in writing.

This is a summary of a legal notice that details SFHSS privacy policy. The full legal notice is available at sfhss.org.

You may also contact SFHSS to request a written copy of the full legal notice.

Glossary of Healthcare Terms

Accountable Care Organization
A payment and healthcare delivery model that aligns medical group reimbursements with meeting coordinating care and quality and cost targets. Also called ACO.

Ambulatory Care
Care provided in outpatient setting.

Benefits Coverage Period
Dates when your health insurance coverage begins and ends.

Brand-Name Drug
FDA-approved prescription drugs marketed under a specific brand name by the manufacturer.

COBRA
This federal law allows employees and dependents who are enrolled in an employer-sponsored plan to temporarily continue receiving health coverage after certain qualifying events like termination or divorce.

Co-Insurance
Co-insurance refers to the amount of money that a member is required to pay for healthcare services, after any required deductible has been paid. Co-insurance is specified by a percentage. For example, the employee pays 15% toward the charges for a covered service and the insurance company pays 85%.

Co-Pay
The fee you pay each time you utilize a healthcare service or fill a prescription.

Covered California
California state health insurance exchange where people can purchase affordable insurance if they lose coverage: coveredca.com.

Deductible
The specified amount you must pay for healthcare in a plan year before the plan will begin to cover all or a portion of your costs. Some plans have no deductible.

Dependent
A family member who meets the eligibility criteria established by SFHSS for health plan enrollment.

Dental Health Maintenance Organization (DHMO)
Entity that provides dental services through a limited network. DHMO participants only obtain service from network dentists and need pre-approval from a primary care dentist before seeing a specialist.

Effective Date
The calendar date your healthcare coverage begins. You are not covered until the effective date.

Employee Premium Contribution
The amount you must pay toward health plan premiums.

Employer Premium Contribution
The amount your employer pays toward health plan premiums.

Employer-Subsidized Benefits
Benefits that are paid for, all or in part, with money contributed by the employer.

Enrollee
Individual enrolled in a health plan.

Explanation of Benefits (EOB)
Written, formal statement sent to PPO enrollees listing the services provided, amounts paid and costs billed by the health plan.

Evidence of Coverage (EOC)
The Evidence of Coverage is a legal document that gives details about plan benefits, exclusions and how to get the care you need. It explains your rights, benefits and responsibilities as a member of your plan and the plan providers' responsibilities to you. EOCs are available on sfhss.org.

Exclusions
The list of conditions, injuries, or treatments that are not covered under your health insurance policy. Exclusions are listed in the Evidence of Coverage.

Flexible Spending Account (FSA)
An account that you contribute to pre-tax, which reimburses you for qualified healthcare and dependent care expenses.

Formulary
A comprehensive list of prescription drugs that are covered by a medical plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost-effective. The formulary is updated periodically.

Generic Drug
FDA-approved therapeutic equivalent to a brand-name prescription drug, containing the same active ingredient and costing less than the brand-name drug.

Guaranteed Issue
There are insurance policies that are guaranteed to be issued. That means regardless of your health, you cannot be declined or turned down for coverage.

Health Maintenance Organization (HMO)
An entity that provides health services through a closed network. Unlike PPOs, HMOs either employ their own staff or contract with specific groups of providers. HMO participants typically need pre-approval from a primary care provider before seeing a specialist.

Imputed Income
IRS regulations require that the value of non-cash compensation, including employer contribution toward health premiums for an employee's domestic partner, be reported as taxable income on federal tax returns.

In-Network
Providers or facilities that contract with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network provider.

In-Patient
Services that are provided in a hospital and require admission and an overnight stay.

Medical Group
An independent group of physicians and other healthcare providers that contract to provide services to members of an HMO.

Member
An employee or retiree designated as the primary plan subscriber, per SFHSS rules.

Non-Formulary Drug
A drug that is not on the insurer's list of approved medications. Can only be prescribed with a physician's special authorization.

Open Enrollment
A period of time when you can change your health benefit elections without a qualifying event.

Out-of-Area
A location outside the geographic area covered by a health plan's network of providers.

Out-of-Network
Providers or facilities that are not in your health plan's provider network. Some plans do not cover out-of-network services. Others charge a higher co-insurance.

Out-of-Pocket Costs
The actual costs you pay–including premiums, co-payments and deductibles–for your healthcare.

Out-of-Pocket Maximum
The highest total amount you will spend in a year on out-of-pocket medical costs. Once you reach out-of-pocket maximum, your plan pays 100% of covered service costs.

Out-Patient
Services that are provided in a clinic or doctor's office and do not require overnight admission to the hospital.

Preferred Provider Organization (PPO)
Provides in-network services to subscribers at negotiated rates, but allows subscribers to seek service from out-of-network providers, often at a higher cost.

Premium Contributions
The amount charged by an insurer for healthcare coverage. This cost is usually shared by employer and employee.

Primary Care Physician (PCP)
Doctor (or nurse practitioner) who coordinates all your medical care. HMOs require all plan participants to be assigned to a PCP.

Privacy
SFHSS complies with federal and state laws that protect personal health information. For details visit: sfhss.org/health_service_board/privacy_policy.html

Qualifying Event
A life event that allows you to make a change in your benefit elections outside Open Enrollment. Includes marriage, domestic partnership, separation, divorce or dissolution of partnership, birth or adoption of a child, death of a dependent, obtaining or losing other health coverage.

Reasonable and Customary
The average fee charged by a particular type of healthcare practitioner within a geographic area. Often used by medical plans as the amount of money they will pay for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference.

Same Day Surgery
Surgery procedures performed at an ambulatory care center or in-patient hospital without an admission or over night stay.

Specialty Drug
New types of drugs to treat specific illnesses.

Nurseline, Urgent Care, Telemedicine, Online Resources

Get care now and when you need it. Medical care is getting more convenient. Save yourself time and money by using these different services.

24/7 Nurse Line

Call a free nurse advice line and speak to a registered nurse. Get answers to your questions about health problems, illness or injury. The nurse can also help you decide if you need routine, urgent or emergency service.

Urgent Care

Sometimes you need medical care quickly, but a trip to the emergency room isn't necessary. Visit an urgent care center when it is after hours for your regular provider and you need prompt attention for an illness or injury that is not life-threatening. Urgent care offers the convenience of same-day appointments and walk-in service.

Telemedicine

City Plan PPO Members: A video or virtual visit is an appointment with a telemedicine doctor that is done through the camera on your mobile device or computer.

Blue Shield Members (Trio HMO & Access+ HMO): Access board-certified doctors 24/7/365 by phone or video through teladoc.com/bsc.

Kaiser Permanente: Access by video through: mydoctor.kaiserpermanente.org/ncal/videovisit/#.

Go Online

Email your doctor, access your records online, or renew your prescriptions.

Blue Shield of California Trio HMO and Access+ HMO	Kaiser Permanente HMO	City Plan PPO
24/7 Nurseline		
Trio HMO: (877) 304-0504 Access+ HMO: (877) 304-0504	Nurse Advice 24/7 (866) 454-8855	Nurseline 24/7 (800) 846-4678
Urgent After Hours Care		
Trio HMO: (855) 747-5800 blueshieldca.com/sites/imce/trio.sp Access+ HMO: (855) 256-9404 blueshieldca.com	(866) 454-8855 my.kp.org/ccsf	(866) 282-0125 welcometouhc.com/sfhss
Telemedicine		
Blue Shield members can access Teladoc's U.S. board-certified doctors 24/7/365 to resolve many non-emergency medical issues through phone or video consults. Visit teladoc.com/bsc or call (800) 835-2362.	When scheduling an appointment in person or through the Appointment and Advice line (866) 454-8855, ask if a video visit is right for your symptoms. You may be offered a video visit.	Members can access Virtual Visits by registering on myuhc.com, tab on the right, or by accessing health4me app, under *Menu – Find and Price Care*. Costs are the same as an office visit.

Key Contact Information

San Francisco Health Service System
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: (415) 554-1750
Toll Free: (800) 541-2266
Fax: (415) 554-1721
website: sfhss.org

Well-Being
1145 Market Street, 1st Floor
San Francisco, CA 94103
Tel: (415) 554-0643
email: wellbeing@sfgov.org

Employee Assistance Program
Tel: (415) 554-0610

Health Service Board
Tel: (415) 554-0662
email: health.service.board@sfgov.org

MEDICAL PLANS			
Blue Shield of California	Trio HMO: (855) 747-5800 Access+: (855) 256-9404	Trio HMO: blueshieldca.com/sites/imce/trio.sp Access+ HMO: blueshieldca.com	Group W0051448 (Trio HMO and Access+ HMO)
Kaiser Permanente	(800) 464-4000	my.kp.org/ccsf	Group 888 (North CA) Group 231003 (South CA)
City Plan PPO UnitedHealthcare	(866) 282-0125	welcometouhc.com/sfhss	Group 752103
DENTAL and VISION PLANS			
Delta Dental PPO	(888) 335-8227	deltadentalins.com/ccsf	Group 09502-0003
DeltaCare USA DHMO-style	(800) 422-4234	deltadentalins.com/ccsf	Group 71797-0001
UnitedHealthcare Dental DHMO *(formerly Pacific Union Dental)*	(800) 999-3367	welcometouhc.com/sfhss	Group 275550
VSP Vision Care	(800) 877-7195	vsp.com	Group 12145878
FSAs and COBRA			
P&A Group FSA	(800) 688-2611	padmin.com	
P&A Group COBRA	(800) 688-2611	padmin.com	
VOLUNTARY BENEFITS			
WORKTERRA (EBS)	(888) 392-7597	workterra.net	
SECOND MEDICAL OPINION			
Best Doctors	(866) 904-0910	members.bestdoctors.com	
LONG-TERM DISABILITY (LTD) and GROUP LIFE			
Aetna LTD Long-Term Disability	(866) 326-1380	www.aetnadisability.com/login.aspx	Group 839201
Aetna Group Life	(800) 523-5065	aetna.com/group/aetna_life_essentials	To initiate a claim, contact SFHSS at (800) 541-2266
OTHER AGENCIES			
SFERS Employees' Retirement System	(415) 487-7000	mysfers.org	Pension benefits
Dept. of the Environment	(415) 355-3700	sfenvironment.org	Commuter benefits
CalPERS	(888) 225-7377	calpers.ca.gov	Pension benefits
Covered California	(888) 975-1142	coveredca.com	Health insurance exchange

For more information visit sfhss.org or call Member Services at (415) 554-1750.

SFHSS.ORG